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COMMUNITY HEALTH CENTERS

Challenges in Transitioning to Prepaid Managed Care

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Madam Chairman and Members of the Committee:

We are pleased to be here to discuss our report that is being released today on the impact of managed care on federally supported community and migrant health centers.[1]

Historically, these centers were established to provide underserved communities with medical and enabling services such as health education, transportation, and linkages with other social services. Today, over 1,600 health care delivery sites provide services to more than 7 million people. Many of the patients who receive services at these centers live in economically depressed areas, have incomes below the federal poverty level, are uninsured, or receive Medicaid health benefits.

Since 1989, the Medicaid program has reimbursed health centers for the reasonable cost of services provided to their beneficiaries. More recently, as states have moved to managed care delivery systems for their Medicaid populations, community health centers are transitioning from cost-based reimbursement to a monthly per capita rate for each beneficiary. As health centers transition to prepaid managed care, concerns have been raised that capitated reimbursement and other aspects of managed care could diminish centers' ability to provide medical and enabling services and weaken their financial positions.

To address these concerns we identified 10 health centers in four states--Arizona, Florida, Massachusetts, and Pennsylvania--with varying degrees of experience with Medicaid prepaid managed care arrangements.[2] Health centers in Arizona have over 10 years experience while some centers in Florida entered such arrangements 5 years ago. We also visited health centers in Tennessee and Washington to learn about their responses to recent changes in their Medicaid programs. In addition, we met with

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[1]Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (GAO/HEHS-95-138, May 4, 1995).

[2]Nine of the health centers we reviewed receive community health center grants while the tenth center receives both a community and a migrant health center grant. We did not examine any issues unique to financing care for migrant populations in a prepaid managed care system.

Bureau of Primary Health Care (BPHC) officials to learn about their efforts in assisting centers to transition to prepaid managed care.[3]

In brief, we found that all 10 health centers are serving more patients and have increased the amount they spend on maintaining or expanding a variety of enabling services. Seven centers also increased the amount spent to subsidize care for low-income patients. In many cases, centers were able to expand services because of modest improvements in their overall financial positions. Such improvement was related to increases in revenues from a variety of sources--other federal and state grants--that were greater than the centers' overall expenses. However, some centers may still be vulnerable to financial risks because they had little cash on hand to cover unexpected expenses.

We also identified several lessons learned from early health center experiences in transitioning to managed care that continue to be relevant, such as the need to negotiate adequate capitation rates and to be very cautious when accepting financial risk. Finally, we found that the BPHC has played a supportive role in helping centers make the transition to prepaid managed care by providing a variety of training and technical assistance. This assistance often incorporated some of the lessons learned from early health center experiences in prepaid managed care.

BACKGROUND

In fiscal year 1994, the Congress authorized $663 million for the Community and Migrant Health Center program to support about 627 health center grantees. Federal health center grants and Medicaid provide the two largest components of health center revenues; in 1994, 35 and 34 percent, respectively. Health centers may also receive other federal, state, and local grants to support their activities.

Federally supported health centers are expected to target services to those with the greatest risk of going without needed medical care. In addition to comprehensive primary care services

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[3]BPHC sets policy and administers the health center program. BPHC is part of the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services' Public Health Service (PHS). Ten regional PHS offices assist BPHC in managing the program. The regional offices are primarily responsible for monitoring the appropriate use of program funds by grantees.

and case management,[4] centers are expected to offer enabling services, such as transportation, health education, counseling, and translation services, and linkages with other social services.

Although health centers are required to offer their services to all individuals regardless of ability to pay, the centers must seek reimbursement from those who can pay as well as from third-party payers such as Medicaid, Medicare, and private insurers. Patient fees are determined from a sliding fee schedule that is tied to federal poverty levels.

Faced with rapidly rising Medicaid budgets, more and more states are putting their Medicaid beneficiaries in managed care plans in order to control costs while providing access to care.[5] The states' adoption of managed care delivery systems, particularly the use of capitated payment, has also been a challenge for many health centers. Under capitation, states pay health care plans a per capita amount each month to provide or arrange for all covered services.

The challenge for centers is that they now face more financial risks. Previously, centers received Medicaid fee-for-service reimbursement that, by federal law, had to cover the reasonable costs of service. Under prepaid managed care, the centers are paid a set amount for each beneficiary up front; if the rate is too low to cover costs, the centers could lose money and would need to draw from other revenue sources to offset the loss. To the extent that centers do lose money, they may deplete cash reserves that are used to subsidize low-income care or other center activities.

HEALTH CENTERS PARTICIPATING IN MANAGED CARE CONTINUE TO PROVIDE NEEDED SERVICES

Prepaid managed care has grown dramatically in community health centers. In 2 years, from 1991 to 1993, the number of Medicaid prepaid patients at health centers increased 55 percent to almost 450,000, and the number of health centers accepting capitated payments increased 25 percent, from 92 to 115.

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[4]Case management services (including counseling, referral, and follow-up services) are designed to assist health center patients in establishing eligibility for and gaining access to federal, state, and local programs that pay or provide for medical, social, educational, or related services.

[5]See, for example, Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Capitated payments ranged from $12 to $38 per member per month for primary care at the centers we studied. The variation in capitation rates is related to differences in the services covered under health plan contracts at each center.

Despite the concern that capitation would make it difficult for health centers to maintain their service levels, the 10 health centers we visited have actually increased access to medical care and enabling services while operating in prepaid managed care systems. The centers were able to continue to provide such services in part because they receive other revenues to support them. From 1989 and 1993, the number of medical patients served in the 10 centers increased almost 30 percent,[6] and the number of patient visits or encounters increased almost 40 percent. During the same time, 7 of the 10 health centers also increased their spending on subsidized low-income care.

Moreover, the centers expanded or enhanced enabling services, such as counseling and translation, in response to growing community needs. Nine of the 10 centers increased the number of full-time-equivalent staff involved in providing these kinds of services.

FINANCIAL SITUATION IMPROVED BUT CENTERS ARE VULNERABLE TO UNEXPECTED LOSSES

While the community health centers maintained or expanded access to medical and enabling service in their communities, financially the message is mixed. Overall, centers have improved their financial situations, but some remain vulnerable.

The health centers we reviewed showed increases in center year-end fund balances, due to revenue increases from a variety of sources that exceed spending growth. Between 1989 and 1993, total revenues at the 10 centers increased from 35 percent to 142 percent.[7]

Center earnings from prepaid managed care were modest, at best. Although six centers reported prepaid managed care earnings of less than $100,000 in 1993, three other centers

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[6]Individual center increases ranged from 4 percent to 164 percent.

[7]The degree to which the centers were involved in prepaid managed care varied considerably. Prepaid managed care ranged from 3 to 52 percent of the total health center revenues. There were also differences in the proportion prepaid managed care revenues represented of total Medicaid revenues, ranging from about 12 to 100 percent of total Medicaid revenues.

reported losses of up to $124,000. These losses were offset by revenues from other sources. Although earnings were modest, several center directors credited the predictability of monthly capitation payments in assisting them in financial planning.

Regardless of the increases in fund balances, none of the 10 centers' had enough cash on hand to cover 60 days of operating expenses--the suggested BPHC benchmark--and 3 centers had less than 10 days' worth of cash on hand.

Low cash balances could especially be a problem for centers with more than 15 percent[8] of their total revenue from prepaid managed care if they encounter significant unexpected expenses resulting from inadequate capitation rates or assumption of risk for nonprimary care services. Seven of the centers we reviewed receive more than 15 percent of their total revenue from prepaid managed care. Four have assumed financial responsibility for nonprimary care services and have cash reserves of 31 or fewer days of operating expenses.

Centers can also be financially vulnerable when capitation rates do not fully cover the cost of the care they provide. Centers are faced with either depleting their reserves or cutting back services. Several health center directors told us that their capitated reimbursements are adequate to cover the costs of medical services, and some believed that their capitation rate roughly equaled what they would receive from cost-based reimbursement. In most cases, however, center directors could not provide us with data to substantiate their position.

LESSONS LEARNED FROM EARLY TRANSITION TO PREPAID MANAGED CARE

At least two lessons can be drawn from health centers' experience with managed care. The first is that health centers that do not participate in Medicaid prepaid managed care arrangements risk losing a significant portion of their target population and Medicaid revenues. Losing this funding could be catastrophic to a health center. For example, a health center in Washington state abruptly lost about one-third of its patients and 17 percent of its revenue in 1994 when its relationship with the only local Medicaid health plan was discontinued.[9] Had the

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[8]This is a BPHC benchmark.

[9]Since the health plan limited membership to individual physicians, the center's contract was through a physician employed by the center. When the physician resigned, the center's other physicians were either not willing to contract with the plan or were unacceptable to the health plan because of

center not reestablished its relations with the health plan, the center's director told us it would have had to close its doors due to the loss of patients and revenues.

The second lesson is that although health centers need to move to managed care and can do so successfully, transitions can be painful. For example, one center in Arizona experienced significant problems. Initially, the capitation rates were inadequate to cover the costs of serving patients in Arizona's Medically Needy/Medically Indigent eligibility category, and the center had accepted financial risk for all medical services. In addition, the center had neither adequate information systems to manage the risk it had assumed or adequate capital to absorb losses. It was forced to cut back on its medical and enabling services as it reorganized through bankruptcy. The Arizona center has completed its restructuring and is now a provider for several health plans. The health center no longer accepts full financial risk for referrals or hospitalizations.

BPHC PROVIDES ASSISTANCE IN TRANSITIONS TO PREPAID MANAGED CARE

Because a substantial federal investment is at stake as well as a necessary community service, we examined the role of BPHC in assisting centers in the sometimes difficult transition to managed care. BPHC, in cooperation with the National Association of Community Health Centers, provides training and technical assistance to help centers that are interested in or transitioning to a prepaid managed care system. Some of the topics included in their technical assistance address lessons learned from health centers' experiences with prepaid managed care. For example, BPHC has developed various self-assessment tools that offer guidance on different aspects of managed care, such as negotiating with managed care plans, and assessing the market area and internal operations. Another service offered by BPHC is reviewing contracts between centers and health plans.[10] The contracts are typically reviewed by outside private-sector managed care specialists who provide written advice on specific sections that could be revised more favorably for health centers.

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concerns about admitting privileges at the local hospital and their ability to guarantee 24-hour coverage. All Medicaid beneficiaries in the health center's service area were enrolled in the health plan. The physician through whom the health plan contracted returned to the health center after 7 months.

[10]Our review of health center contracts with managed care organizations showed that many left key contractual elements (scope of services, access to accounting information, assignment of members, and others) unspecified or unclear.

In 1994, BPHC reviewed 45 contracts for approximately 30 health centers. Several training sessions are available to BPHC grantees. Subjects include managed care basics, negotiating a managed care contract, medical management, and rate setting. In 1994, 48 sessions in 35 states were provided. In addition, during 1994, 65 health centers requested and received one-on-one technical consultations on managed care issues.

BPHC also assists centers in planning and initiating participation in managed care arrangements through the Integrated Service Network (ISN) Development Initiative, established in 1994.[11] These one-time awards are used by health centers to plan and develop an integrated delivery system with other providers to ensure access for the medically underserved.

CONCLUSIONS

As states move to managed care to control costs and improve access for their Medicaid populations, the number of participating health centers continues to grow. Although managed care is compatible with their mission of providing access to health care for medically underserved populations, health centers face substantial risks and challenges as they move into these arrangements. Such arrangements require new knowledge, skills, and information systems. Health centers that lack this expertise face an uncertain future. Those in a vulnerable financial position are at even greater risk.

Possible changes in Medicaid and funding for other federal and state health grant programs could significantly affect the cash reserves available at health centers. If the number of patients reimbursed under prepaid managed care continues to grow, health centers must face building cash reserves while not compromising services to their communities.

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[11]Approximately $6 million was awarded to 29 health centers in 1994.

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Madam Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Committee members may have.

For more information on this testimony, please call Rose Marie Martinez, Assistant Director, at (202) 512-7103 or Paul Alcocer at (312) 220-7615. Other major contributors included Jean Chase, Nancy Donovan, and Karen Penler.

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